Workers' Compensation/Occupational Health National Trends Study

Final Report

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I. Introduction/Background

Under contract with the Washington State Department of Labor and Industries (L&I), researchers at the University of Washington (UW) Department of Health Services conducted the National Trends Study. The goal of the study was to describe innovative approaches to health care delivery for injured workers which:

- are occupational health focused (i.e., use specific physician networks and protocols developed for workers' compensation coverage, and emphasize return to work, safety, and prevention)
- could be adapted to Washington state's workers' compensation regulatory environment.

In 1995, L&I implemented the Managed Care Pilot (MCP), in which it purchased medical services for injured workers through capitated managed care arrangements. The two MCOs with which L&I contracted had occupational medicine programs that included primary care physicians trained in occupational medicine.

An independent evaluation of the MCP, conducted by the UW Department of Health Services, lent support to the notion that occupational medicine services, delivered through managed care arrangements, can improve case management and lower workers' compensation costs, without sacrificing quality of care (as measured by functional outcomes). Results of the study also indicated that this approach was associated with increased employer satisfaction and decreased employee satisfaction.

The MCP was conceived in the context of the overall health care reform envisioned by the Health Services Act of 1993 (HSA). This included a delivery system based on managed care and the provision of services through certified health plans. Universal coverage for all state residents was to be guaranteed. For purposes of the MCP, which restricted participating employees to defined networks of providers, the HSA exempted L&I from the State law that ensures a worker's right to choose an attending physician. In the context of overall health care reform, with the promise of universal coverage, organized labor was willing to consider the pilot's restricted freedom of choice. However, in 1995, the Health Improvement Act largely replaced the 1993 HSA, eliminating the promise of universal coverage and increasing stakeholders' resistance to programs which limit the worker's right to choice of physician.

The National Trends Study is part of L&I's current investigation of ways it may implement the successful components of the MCP, without compromising State laws regarding workers' right to choose an attending physician. Information about innovative approaches nationwide is intended to provide L&I with ideas about possible options for Washington state.

II. Methodology

This study used key informant interviews to collect data about managed workers' compensation medical benefits programs. The Department of Labor and Industries provided the names of 31 key informants. Of these, nine people were not reached or declined to participate in the study. Those informants interviewed suggested additional key informants. Telephone interviews were conducted with one* representative from each of 26 organizations (described at the top of the next page**). Each interview lasted about an hour.

The interview tool (developed by the University of Washington researchers, with input from L&I) consisted of a series of open-ended questions covering the following topics:

- structure of the service delivery system, including network composition
- impetus for and timing of program development
- primary prevention activities
- return to work activities
- approach to disability prevention, including management of complex cases
- handling of medical treatment disputes
- quality assurance mechanisms
- performance findings regarding: quality, cost, satisfaction
- incentives and barriers to employee, employer, and provider participation
- policies regarding "opt out"
- policies and experience regarding out-of-network care
- most and least effective features of the program
- recommendations regarding development of successful programs

The interview tool provided the basic structure for each of the interviews. (A copy of the tool is in Appendix C.) Individual questions, identified by L&I as lower priority, were sometimes omitted due to time constraints. In addition, the questions were modified for interviews with informants who, while knowledgeable about the area under study, did not represent particular medical benefits programs. In all interviews, probing questions were asked to clarify informants' answers and to further explore areas of interest.

The researchers took extensive notes during the interviews, summarized the information collected in written form, and then sent the summaries to key informants for confirmation of accuracy. Any editing of the summaries done by the informants was incorporated into the revised interview summary documents.

* Two representatives of one organization participated in one of the 26 interviews.
** See Appendix A for a list of these organizations, catagorized by type.

Description of Informant Sample

The informants interviewed represented a range of organizations as described below.

- *Structure.* The informants included: 1 representative from each of 6 state agencies; 5 representatives of union-based or affiliated organizations (2 from the same organization, interviewed simultaneously, and 2 not connected with particular health care delivery programs); 2 representatives of university medical center-based programs; 10 representatives of multi-state health care programs; 3 representatives of single state health care programs; and 1 representative of a management consulting firm.

- *Size.* Programs described by informants varied greatly in size, the smallest being the Johns Hopkins and Duke University programs (with under 12 providers each), and the largest being CorVel and Workers' Compensation Community Care Network (each with 100,000-150,000 providers, in over 40 states). (See Table 1 in Appendix C for the number of providers in each organization surveyed.)

- *Service Components.* Informants represented programs which differed in terms of whether or not they include case management services, provider networks, and insurance services.

- *Workers' Compensation Focus*. Some of the informants represented companies that provide only workers' compensation services, and some represented companies that provide both general group health and workers' compensation services.

III. Findings

The following sections of the report summarize findings in each of the topic areas investigated. In addition, the data are presented by organizations surveyed in Tables 1-5 of Appendix C.

A. Provider Panels

1. Primary Treating Providers

The types of providers informants listed as primary treating physicians are summarized, by program, in Table 1 of Appendix C. Most informants listed a wide variety of providers. They tended to be less concerned with board certification than with the providers' experience with and interest in workers' compensation issues.

- About a third of the informants stated that all providers serve as primary treating physicians; most of these informants described how case managers refer injured workers to the appropriate provider for initial treatment. The informant from the California State program noted that, while anyone licensed to practice medicine in California can serve as a primary treating physician, the MCOs must have a system to train them in issues related to workers' compensation and occupational medicine.
- Three programs, those associated with Johns Hopkins Medical Center, Duke University Medical Center, and Mt. Sinai Medical Center, reported exclusive use of board certified or residency-trained occupational medicine physicians and interns.

- Six other informants who listed specific types of providers as primary treating physicians included, among them, occupational medicine physicians or aviation/aerospace physicians.
- Another four informants listed non-MD providers (e.g., osteopathic and chiropractic physicians, optometrists, acupuncturists, psychologists, dentists, and podiatrists).

The three informants not associated with specific health care delivery systems had different ideas about primary treating physicians.

- One observed that general practitioners are usually appropriate (if they refer to specialists when needed) since most cases are medical only.[*]
- The second commented that the primary treating physicians need not be occupational medicine physicians, but that occupational medicine physicians should provide consultation and referral.
- The third informant stated that occupational medicine physicians are the ideal primary treating physicians, but that, given the shortage of them, other providers willing to practice *like* occupational medicine physicians must be sought.

2. Chiropractors

With regard to chiropractors serving as primary treating physicians, some informants indicated that they do (or should), some that they do not (or should not), and others (representatives of programs operating in multiple states) that this varies from state to state.

- With the exception of Colorado, the state-run programs surveyed permit chiropractors to act as primary treating physicians.
- Representatives from two of the four union-based or affiliated organizations stated that chiropractors serve or should serve as primary treating physicians, and representatives from the other two noted that they do not or should not serve as primary treating physicians.
- Both of the informants from university-based programs indicated that chiropractors do not serve as primary treating physicians.
- Programs operating in multiple states tended not to allow chiropractors to serve as primary treating physicians unless required by state law.

The most frequent rationale for chiropractors serving or not serving as primary treating physicians was state regulations. In terms of the mechanisms for accessing chiropractic care where chiropractors do not serve as primary treating physicians, informants indicated either that patients self-refer (state law allowing) or are referred by case managers or medical doctors.

[*] This informant, a union representative, also acknowledged a role for occupational medicine physicians, but expressed concern about company doctors who purport to be occupational medicine physicians and are not.

3. Proportion of Different Types of Providers

Only about half of the respondents could provide some estimate of the relative numbers of different types of providers in their programs. Among those who had some idea of the proportions of different providers, their estimates ranged as follows.

- *Occupational medicine:* from 1% (in large, multi-state PPOs) to 64% (at the Duke University occupational health program) of total network, with most programs having less than 25%. According to the informants, there is a very limited supply of practicing board certified occupational medicine physicians.

  Some informants provided other information related to the use of occupational medicine providers. For example, a representative from a national PPO (PhyCor) noted that two-thirds of its clinics have occupational medicine programs (half with a board certified OM physician in charge); another informant pointed out that there is not much demand for occupational medicine physicians in New York, since employers have not been able to direct care; a union-based New York informant explained that they want to develop a group of physicians experienced, but not necessarily board certified, in occupational medicine; and most CorVel (a national PPO) patients are initially referred either to an urgent care center or to an occupational health center, where board certified OM physicians are on staff, but do not necessarily provide the treatment.

- *Chiropractors*: 0% to 12% of total network, with all but one under 8%.

- *Primary Care Physicians*: 4% to 75%, with most under 25% of total network.

- *Other Specialists*: 3% to 90%, with most being 60% or more of total network.

The two union-based informants who do not represent specific health care delivery systems noted that labor should be involved in decisions about the composition of the provider network, for example, through union representatives selecting medical consultants who select providers.

4. Size of Provider Network

As noted in the Methodology section of this report, the size of provider networks varied greatly among the programs investigated. Informants were not asked to comment on the advantages and disadvantages of different network sizes, but some informants did express opinions. Some believe larger networks are more attractive to employers and employees. Others expressed a preference for smaller, more selective networks of high quality providers. One union-based representative noted that free choice does not always guarantee good care, while another union-based representative stressed the importance of preserving worker choice.

B. Impetus for Program Development

Many respondents noted that traditional workers' compensation systems do not address injured workers' needs for timely access to quality care and return to work; nor do they address employers' needs for reasonable costs (medical and indemnity).

Respondents from four states (California, Kentucky, New York, and Florida) cited state legislation – enabling pilot programs and/or mandating delivery models – as the impetus for change. Importantly, the majority of respondents noted that impetus for change occurred outside the legislative process and was a direct result of businesses' (including employers' and insurance carriers') concerns about rising medical and indemnity costs. Almost all informants cited cost as the impetus for change.

The following categories represent the primary reasons for program development, in the order of frequency mentioned. Categories are not mutually exclusive.

- *Cost.* States want to reduce the burden on the budget, and businesses assume directing care allows for more control over costs.
- *Enhancing access to care for injured workers*. Traditional workers' compensation systems were viewed as not providing injured workers with timely access to care, which is a route to reduced time loss and disability.
- *Enhancing the quality of medical care received by injured workers.* State-mandated fee schedules were considered too low to attract high quality physicians. Informants thought directing injured workers to physicians who understand workplace injuries would facilitate timely return to work.
- *Integrating workers' compensation benefits with group health benefits* was an impetus for changing existing workers' compensation programs.
- Some programs were initiated by businesses (both for-profit and not-for-profit) *as a niche product or a new business product in a competitive environment.*
- A few respondents mentioned *high rates of litigation* as motivation for change.

C. Injury Prevention

Fifteen informants reported addressing injury prevention. These efforts fall into six general, overlapping categories; some programs have activities in two or more of these categories.

1. Provide on-site safety inspections, which may result in lower premiums and/or suggested changes in working conditions.
2. Track injury and illness trends, and report them to the employers. Some programs follow up with suggested workplace modifications that address underlying causes.
3. Offer on-site safety trainings, such as body mechanics and proper lifting techniques.

4. Provide general health promotion activities (e.g., smoking cessation, pre-employment functional capacity assessment, drug testing, exercise promotion, and organizational health issue identification).
5. Educate patients about how to prevent future, similar injuries.
6. Provide employer incentives to develop safety programs.

Eight informants reported not addressing injury prevention; following are the reasons.

- Since the health plan is not at risk for services related to workplace safety, there is no incentive to emphasize prevention.
- Customers are not willing to pay for it because they are skeptical of its cost-effectiveness.
- The health plan has not developed a prevention program but plans to in Florida because it bears risk for medical services in that state.
- There has been a 10% reduction in injury rates *without* offering a specific prevention program; trainings on how to respond when an employee has been hurt on the job have resulted in an increased awareness of workplace safety, which has led to behavioral changes.
- The state managed care regulations do not require a focus on injury prevention.

The three informants who are not directly associated with a health care delivery system strongly advocated for inclusion of workplace injury prevention efforts in workers' compensation medical benefits programs. One noted that physicians in industrial medicine clinics are in a unique position to notice and respond to injury trends.

D. Activities to Facilitate Return to Work

The investigated programs offer a wide variety of activities related to return to work (RTW). Nearly all programs emphasize RTW as their number one priority and the ultimate goal of their other activities. Specific RTW activities are noted below in the order of how commonly they were reported and advocated by informants.

- Help employers create job modification/light duty options.
- Work with employers to help them see the value of modified duty to both the injured worker and the company (i.e., how it is in their best interests to offer light duty).
- Maintain contact with – and facilitate communication among – the employer, injured worker, payor, and provider, through case management activities.
- Focus on injured workers' capabilities, rather than on their limitations.
- Have nurse case managers work with the providers – tracking time loss, providing treatment and RTW plans, and defining work restrictions.

- Include rehabilitation in the forms of: actual employment; utilizing provided exercise facilities; or using computer-assisted work simulation programs.
- Emphasize early medical intervention – detection, diagnosis, and treatment.
- Educate injured workers on the importance of RTW (i.e., creating an *expectation* of returning to work).
- Use wage replacement programs to facilitate early and appropriate RTW. For example, in Ohio, some MCOs and TPAs offer a wage replacement program. With approval from [the State] Bureau of Workers' Compensation, the employer continues to pay wages to workers who are off work, instead of the State paying time loss. This keeps premiums down, and employers may work harder to get the employee back to work in some capacity. (Three other key informants who supported wage replacement were labor representatives.)
- Information about job duties given to the provider, possibly in the form of a video tape, helps them to create job modifications and to facilitate RTW.
- Other, less frequently described activities to facilitate RTW, include: (1) use of high standards of care; (2) moving to a vocational process if the RTW process fails; (3) training physicians to become involved in vocational and socio-economic issues, as well the medical issues; (4) encouraging employers to stay in contact with injured workers, so they continue to feel connected to the workplace; and (5) use of disability duration guidelines, which are based on severity of injury and on vocation.

The two union representatives not affiliated with a specific health care delivery program expressed the following about RTW.

- Early intervention is the key to successful RTW.
- Employers and/or insurers should encourage injured workers to return to work; injured workers respond positively to a message of support.
- Some employers do not abide by the Americans with Disabilities Act because they do not provide appropriate accommodations for their injured employees.
- Some employers retaliate against injured workers by not providing RTW opportunities.
- RTW is often difficult in the construction industry, due to the temporary nature of employment.

1. Provider Involvement

As noted above, there are a variety of ways in which providers are involved in facilitating RTW. Nearly half of the informants reported that the providers are directly involved in developing modified job duties, usually working with the employer and/or a nurse case manager (associated with the health care delivery organization) to find a job the injured worker can perform.

Many informants also noted that providers' primary involvement in creating job modifications that facilitate return to work is assessing the workers' functional capacity and writing activity restrictions. After the physicians write the restrictions, it is sometimes the case managers who

work with the employers to create job modifications and/or find another job at the firm. Several informants emphasized the providers' role in determining what the worker *can* do, rather than what s/he *cannot* do.

Two informants stated that, in general, physicians do not understand the workplace and are not good at workplace assessments. One noted that an exception would be some occupational medicine physicians, who are trained to identify activities that could aggravate an injury or impair healing, and who are helpful in devising modifications which address a specific condition. A labor representative suggested that industrial or occupational medicine nurses or social workers can better assess the industry, earn workers' trust, and understand the practical realities of the workplace. Another labor representative suggested that providers are more effective in facilitating RTW when the injured worker feels the doctor is her/his advocate, and is not only representing the employer's needs.

2. Worksite Visits

Approximately one-third of the informants reported that physicians visit the worksites in order to better understand what jobs really entail, which helps them to suggest appropriate job modifications. Some physicians visit prospectively, both to learn about safety and health issues, and to better understand transitional duty options.

Many programs send a nurse case manager or other appropriate staff member (e.g., ergonomist or vocational counselor) to visit the worksites. Following are some of the tasks that are performed at these worksite visits:

- conduct worksite evaluations and ergonomic assessments
- help implement ergonomic resolutions or modifications of the job descriptions
- understand job functions so they can make good RTW decisions
- assess job modifications
- help accommodate work restrictions
- provide skills training, vocational testing, and vocational placement activities.

Four programs do not send staff to the worksites, due in part to limited human resources.

E. Activities to Prevent Disability

It is notable that many informants list modified work duty, early medical intervention, and case management as both facilitating return to work and preventing disability. Most informants believed strongly in the connection between appropriate RTW and disability prevention.

- *Modified Duty.* Many informants emphasized that the most important activity in preventing disability is having good temporary transitional work programs, because working injured workers recover faster. It was generally agreed that the longer an injured worker is off work, the more likely permanent disability becomes. One informant pointed to *expectations* as the key: from the first date of injury, all parties (insurer, injured worker, physician, and employer) should be planning for the employee's return to work; with everyone aiming for

the same date, the employee is more likely to reach that goal. Another informant (a university-based physician) stated that if the restrictions he prescribed carried the risk of job loss, he would personally discuss options with the employer.

- *Immediate Medical Attention / Early Intervention.* Informants pointed to how immediate medical care: (1) facilitates RTW; (2) helps prevent disability; (3) contributes to decreased litigation; and (4) leads to higher satisfaction among injured workers, which is part of quicker recovery and RTW.

- *Early and Intensive Case Management.* Many informants emphasized the importance and cost-effectiveness of early and intensive case management in preventing disability. They noted that this case management should: (1) be proactive; (2) begin the first day an injured worker is seen, or no later than after three days of time loss; (3) include frequent contact with all involved parties throughout treatment; and (4) have the dual goals of good clinical outcomes and minimal time loss.

Informants reported three additional activities to prevent disability.

- Address psycho-social and vocational, as well as medical issues, because injured workers have different needs at different stages of recovery.
- Educate injured workers about the injury and what to expect during recovery.
- Use an interdisciplinary approach, including early referrals to physical or occupational therapy.

1. "At risk" Cases

When asked how "at risk" cases (defined as those with four to six weeks of time loss) are handled, most informants reported that the length of time loss does not trigger special handling of cases. On the contrary, many informants report that: (a) "at risk" cases are handled no differently than other cases, and (b) early and intensive case management and return-to-work processes reduce the number of cases with lengthy time loss. Case management often begins right away, or as soon as time loss begins accumulating. Ten informants, however, mentioned that certain diagnoses or particularly severe cases are given more intensive case management from the beginning of care.

A union representative noted that daily contact with the case manager is crucial for IWs with long time loss durations. This helps to maintain a connection between the IW and the workplace.

2. Case Managers

"Case manager" is a generic term we use to simplify the range of titles used by the informants. While most case managers were nurses, the investigated programs use a variety of types of case managers, with varying professional classifications, backgrounds, training, and educational levels, such as:

- occupational health nurse
- occupational health specialist

- nurse
- patient advocate
- certified case manager
- field case manager
- vocational manager/consultant/counselor
- certified rehabilitation counselor/therapist
- physical therapist
- utilization review specialist
- industrial hygienist
- return-to-work specialist
- safety professional
- ergonomist
- care coordinator
- nurse practitioner
- other non-medical personnel (such as former claims examiners)

The case managers perform the following types of tasks.

- Communicate with the physician to assure that the injured worker is monitored closely while off work.
- Review cases for appropriateness of care; monitor care for expected progression toward recovery; and detect variances or abnormalities by reviewing bills and patterns of treatment.
- Facilitate communication between the involved parties.
- Act for the injured workers as a bridge to medical care and to the workplace.

The role of the case manager as a worker advocate was encouraged by several informants. One informant reported that some injured workers loose self-confidence regarding their employment, which magnifies the need for the case manager to facilitate the RTW process by interfacing with the injured worker, physician, and employer.

Three programs train their case managers in occupational health and workers' compensation issues. One program, UNITE, has no case managers, nor a formal system of case management, due to limited resources.

F. Quality Assurance Mechanisms

1. Protocols

Of the 13 programs using treatment protocols or guidelines, the majority use a combination of commercially available protocols, protocols designed in-house, and/or state-mandated protocols. The commercial products most often used, whether alone or in combination, are Milliman & Robertson, Quality First, and InterQual. The Presley-Reed Medical Disability Advisor was mentioned by two respondents. Two other programs rely on the guidelines developed by the American College of Occupational and Environmental Medicine.

Several respondents emphasized the use of treatment protocols to facilitate treatment, not to restrict it, and to train physicians in managing workplace injuries. One reason cited for the development of in-house protocols was the belief that commercial products do not adequately address disability management. One respondent stated that treatment protocols, while effective for some injuries, are not effective for lower back strain, where return to work guidelines must be specific, not only to the injury, but also to the job and type of industry.

2. Board Certified Occupational Medicine Medical Director

A third of the surveyed programs have medical directors who are board certified in occupational medicine. Several have medical directors who have experience in occupational medicine, although boarded in another area, such as internal medicine, surgery, emergency medicine, neurology, or aerospace medicine. A few informants noted that a portion of their locations or plans have a board certified occupational medicine medical director. Several respondents noted that it is more important that the medical director be familiar with the realities of the workers' compensation system than it is to be board certified in occupational medicine.

3. Accreditation

About half of the programs surveyed were accredited by NCQA, JCAHO, and/or URAC.[*] Three respondents noted that NCQA requirements are followed although the programs are not NCQA accredited. Another explained that their internal quality assurance review is modeled after NCQA, though not quite as rigid. This same program is planning future accreditation by URAC. Two other plans not currently accredited by NCQA are planning to be in the near future.

Of those with no formal accreditation, the following reasons were reported:

- Accreditation is not required by the state.
- The plan relies on the credentialing of providers to assure quality.
- The plan relies on state mandates regarding utilization review.

G. Dispute Resolution Processes

Nearly all informants indicated that they do have a formal process for handling medical treatment disputes which is specifically for injured workers. Several cited state requirements as the reason for having such a procedure. At least two informants responded that their programs use alternative dispute resolution processes to handle medical treatment disputes. A few informants said they do not have an internal formal process for handling medical treatment disputes, but noted that their programs defer to state regulations.

H. Employee Incentives and Barriers to Participation

1. Incentives for Employee Participation

Informants whose programs operate in areas where workers choose voluntarily to use their services were asked what incentives they offer to attract injured workers. With the exception of two national PPOs whose customers (employers) sometimes offer financial incentives to employees to go to a network provider, the surveyed programs do not use formal incentives. One union representative, however, stated that workers *ought* to share in savings gleaned from workers' compensation programs that use a limited provider panel.

[*] National Committee for Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, and/or the Utilization Review Accreditation Commission. See Appendix A for a list of these and other acronyms used in this report.

Several informants noted that they do not want to force employees to use network providers; rather, they want to create a reputation for providing high quality care and good customer service that would attract injured workers. Several informants emphasized the importance of injured workers perceiving the providers as allies, not as agents of the employers, who only want to get them back to work as soon as possible. Four informants (one of whom was a labor representative) stated that injured workers – especially those with no previous affiliation with a clinic or physician – actually appreciate help from their employers in accessing care for workplace injuries.

Although informants identified no formal incentives, they described various characteristics of their programs that attract injured workers.

- respectful treatment and timely care from the most skilled physicians
- access to a large number of providers
- the same providers for workplace injuries and illnesses as for general health care
- an alternative to the regular workers' compensation hearing process, which is known for its lengthy delays and which may require representation by an attorney
- a user friendly system, including worksite training about how to use it
- one-stop shopping so injured workers can get their medical care, x-rays, physical therapy, and medications all in the same location
- access to assistance with filing workers' compensation claims and getting social services
- multi-lingual services
- providers located conveniently near workplaces
- a toll free phone number to help injured workers find providers
- credentialed network providers, which is an indication of quality

2. Barriers to Employee Participation

Informants reported the following as barriers to employee participation, or reasons injured workers may not want to use network providers.

- Some may see network providers as "company doctors," who will put the company's or the insurer's interests before the injured worker's.
- The clinic's hours are inconvenient.
- Outside of the metropolitan areas, network providers are not conveniently located, because occupational medicine clinics are established where there is a concentration of employers.
- Sometimes it is difficult to get an appointment; all the physicians are academics, so they have limited time. An injured worker's particular physician may not be available on the day or at the time s/he needs.
- Most systems are developed without input from injured workers.
- Employees may have reservations about "managed care" in general.
- Some prefer to go to a physician with whom they have an established relationship.

- Employees can access care only if their employers have a formal relationship with the MCO.
- Some do not know they are supposed to go to a network provider; the employers have not educated staff about the program.
- A small percentage of injured workers don't want to go to network providers because they want to defraud the system.

I. Employer Incentives and Barriers to Participation

1. Incentives for Employer Participation

Of the informants interviewed, 15 represented workers' compensation programs in which employers participate *voluntarily*. When asked about incentives used to encourage employer participation, these informants pointed to opportunities to:

- direct care
- decrease costs
- increase employee productivity.

Three informants noted state regulations that govern these incentives. In Kentucky and California, participation in managed care affords employers an increased ability to direct care. Also in Kentucky, employers who do not participate in managed care must pay separately for a utilization review plan certified by the Sate; but within managed care, this expense is included in the regular premium. In Colorado, employers can be eligible for lower premiums if they meet certain criteria, such as reporting claims within 24 hours and having a fully operational loss prevention program.

Aside from state regulations, informants pointed to the ability of their programs to deliver high quality care and to reduce costs. HealthSouth Corporation cited evidence that its program helps to keep indemnity costs down and employee productivity up. Similarly, CorVel Corporation noted that employers can realize significant reductions in costs and return-to-work timeframes; and Healthcare First guarantees a reduction in employer loss experience. Other informants cited the cost-saving, quality enhancing components of their programs as: early intervention, return-to-work focus, medical management, care management, access to networks, and alternative dispute resolution process.

In addition, some informants pointed to circumstances unique to their states or programs. In California, some of the certified MCOs are linked with workers' compensation carriers that offer premium discounts (about 10%) to employers. Finally, some employers send employees to the Duke University program because of relationships they have developed with staff there.

2. Barriers to Employer Participation

When asked about barriers to employer participation in their programs, informants referred to:

- regulatory requirements and administrative work
- cost, where less expensive health care programs are available

- lack of perceived incentives
- fear of employee dissatisfaction with restricted choice
- insurance carrier opposition based on perceived loss of control over claims.

Following are examples of regulatory requirements and related administrative work which might discourage participation.

- In New York, employers must offer two State-certified MCOs and cannot participate if there is no certified MCO in the counties in which they are located.
- In California, an employer must offer a choice of two plans, notify employees of their right to opt out, and deal with a confusing variation in days of employer control of care.
- In order to contract with the Health Insurance Plan of New York, an employer must be licensed as self-insured.
- Only self-insured employers have a choice about participating in the Ohio Bureau of Workers' Compensation (BWC) program; but many of them do not have the required computerized systems, are put off by the costs involved in participating in a highly automated system, and tend not to like the idea of reporting data to BWC.
- Realizing lower workers' compensation premiums in Colorado requires meeting criteria (see "Incentives," on the previous page) that very small employers might not be interested in attempting.
- As cited by the informant from Humana, some employers do not want to have to designate a network and educate employees to use it.

Those informants who noted a lack of employer incentives attributed this to:

- already declining workers' compensation costs (in California)
- employers already having established relationships with local providers
- lack of awareness of programs.

J. MCO/Provider Incentives and Barriers to Participation

1. MCO/Provider Incentives for Participation

Eleven informants had experience with MCOs or providers who participated voluntarily in workers' compensation managed care programs. They reported that MCOs in Kentucky, New York, and Ohio were attracted by the opportunities to generate new business and/or more income. According to informants, individual providers were most often attracted by the *potential for increasing their patient volumes*. Other provider incentives noted were:

- support with return to work, disability management, and case management (Liberty Northwest)
- provider feedback on performance and educational opportunities (Workers' Compensation Community Care Network)
- provider-friendly environment with resources for research, opportunity to engage in creative work, and competitive salaries (HealthSouth)

- expedited payment system (Liberty Northwest)
- alternative dispute resolution provisions (Center to Protect Workers' Rights).

2. MCO/Provider Barriers to Participation

Informants did not indicate any significant problems in recruiting MCOs or individual providers. However, when questioned about barriers to participation in their programs, informants identified the following factors related to certification requirements, operating regulations, competition, and lack of financial incentives:

- the paperwork, bureaucratic review procedures, and cost (e.g., $500,000 bond in Kentucky) of getting certified (Work Comp Network, Kentucky Department of Workers' Claims, California Department of Industrial Relations)
- required adherence to a structure imposed by state legislation and regulations; for example, the requirement that case management services be included (Kentucky, New York)
- competition where large organizations affiliated with insurance carriers and self-insured employers have already entered the market (Work Comp Network in Kentucky)
- the fact that MCOs are not positioned to make money on the workers' compensation product (New York).

In terms of barriers to participation experienced by individual providers, informants offered the following comments.

- Some providers do not want to handle workers' compensation cases, due to the paperwork involved, the potential for litigation, and/or the trauma-based nature of the work, which makes scheduling difficult (Ohio Bureau of Workers' Compensation, Humana, UNITE, Workers' Compensation Community Care Network).
- Some providers may not want to go through the credentialing process (Humana).
- In some states, the discounted fee schedules discourage participation (Blue Cross of California, Workers' Compensation Community Care Network, CorVel).
- There is some resistance to managed care in general, particularly in rural areas (Humana).
- In employee choice states, many providers do not understand CorVel's capability to direct injured workers to them.
- Providers may object to working within set guidelines, e.g., release to work within set parameters (CorVel).

K. Accessing Care Outside of the Program

For those employees who do not have a choice regarding program participation, the following are circumstances under which they can "opt out" of a program.

- In California, employees can opt out *before* they are injured, by designating a provider in writing and submitting it to their employers.

- In California, if an injured worker does not pre-designate a provider, s/he must wait a specified number of days to see her/his provider of choice. The number of days varies, depending upon the health plan with which the employer participates; it is a minimum of 30 and a maximum of 360 days.
- In New York, employees can leave employer-directed care after 30 days.
- In Arizona and North Carolina, an injured worker can request permission from the State industrial commission to change providers.
- After a first visit to a Healthcare First provider (in Massachusetts), an injured worker can go anywhere.

For informants whose employee population has a choice of where to access care for work-related illnesses and injuries, the questions of when injured workers can "opt out" of the program and when they can access out-of-network care are the same. The following are circumstances under which employees can access out-of-network care (while still participating in the program):

- in an emergency
- if the type of care needed for a particular injury or illness is not provided by in-network physicians within the service area
- if the injured worker receives emergency care after the injury, and continues to see the same provider, who agrees to abide by the MCO rules
- if the injured worker can show that the network did not provide appropriate care or in an accessible manner, e.g., with necessary language translation services
- if an in-network gatekeeper, with health plan approval, refers the injured worker to a non-network specialist
- for the first visit
- if going out of network actually saves money
- if the claim has not yet been accepted
- if the employee has an existing relationship with a provider who agrees to abide by the MCO rules
- if the injured worker continues to see a provider seen before the employer was enrolled in the managed care program
- if it's a second opinion regarding surgery
- if the provider is not on the panel of the MCO chosen by the employer, but is certified by the State Bureau of Workers' Compensation, and if the provider agrees to be managed by a participating MCO
- if the supervisor sends the injured worker elsewhere
- if the out-of-network care is acceptable in terms of quality and cost (i.e., if the care is appropriate and treatment is progressing).

Very few informants reported problems with injured workers going to out-of-network providers. Several noted that many of the injured workers who go out of network do so on the suggestion of an attorney. The following are ways in which employees have been discouraged from seeking out-of-network care.

- Injured workers who get unauthorized care outside of the network may have to pay the bill.
- In order to reduce "doctor shopping," some states cease benefits if an injured worker sees more than three doctors without prior approval.

Five informants emphasized the more positive approach of *encouraging* injured workers to stay in network – by providing timely services, in attractive clinics, with high quality providers who really care about the injured workers' well-being – rather than discouraging outside care through punitive measures.

L. Program Evaluation

Very few of the programs investigated have performed formal evaluations, due to a lack of: incentive, funds, human resources, capacity to collect data, and/or ability to acquire data from other sources (such as employers, insurers, and state funds). Many informants stated they would like to increase their ability to collect data in order to have a clearer understanding of their performance in the areas of:

- employer/client satisfaction
- employee/patient satisfaction
- functional outcomes
- days off work
- injury rates
- re-injury rates
- medical and indemnity costs
- duration and number of treatments
- continuation of employment after returning to work.

Some informants reported anecdotal evidence, inferred results (e.g., employer re-enrollment and lower litigation rates indicating employer and employee satisfaction, respectively), and findings from internal customer satisfaction surveys. Below is a summary of the outcomes reported by informants. (For more detailed information, see Table 4 of Appendix C.)

- Those programs that tracked costs reported savings of 6-50%, noting savings in both medical and indemnity costs.
- A few programs noted an improved medical only to indemnity ratio (i.e., proportionally fewer time loss cases).
- Those programs that surveyed employer and employee satisfaction reported largely positive responses.
- Several programs reported decreased litigation rates.
- Several programs reported a decreased number of lost work days.

A number of the surveyed programs are, or will be soon, conducting formal evaluations. Also reported in Table 4 of Appendix C are the dates those programs anticipate having reports available or articles published.

M. Particularly Effective Aspects of the Programs

When asked which aspects of programs were particularly effective in improving care for injured workers, informants referred most frequently to:

1. prompt access to appropriate levels of care
2. early and on-going case management
3. high quality providers
4. focus on return to work
5. partnerships/teamwork among stakeholders.

Informants observations in each of these areas are summarized below.

1. Access

Rapid access to providers was a common theme. A number of informants referred to notification and care standards which ensure that injured workers are seen within 24 or 36 hours. They also pointed out that facilitating immediate access to treatment tends to reduce both the involvement of attorneys and injured workers' use of lower quality providers. In addition to rapid access to initial care, informants noted that access to specialists is improved by: (a) having on-site network physician advisors, and (b) having at least two providers from each specialty included in the network.

2. Case Management

Informants emphasized how early and on-going case management facilitates:

- communication among involved parties
- access to appropriate and coordinated treatment, and
- an active return to work process.

In most cases, informants were referring to case management systems in which nurse case managers communicate via telephone and use treatment/disability protocols (often electronic) to review and monitor care.

3. Provider Selection, Contracting, and Incentives

Informants noted a number of steps their organizations take to secure high quality provider networks:

- develop their own network, rather than contracting with an existing one
- use a rigorous selection process
- choose primary care providers who are focused on return to work, along with high quality specialists
- spell out contractual expectations, e.g., regarding communication and use of treatment protocols
- make providers accountable for cost and quality
- offer bonuses based on the achievement of outcomes (e.g., RTW)
- give physicians freedom to practice high quality medicine.

4. Return to Work

Informants described return to work programs as beginning immediately after the injury and involving active efforts to return the worker to the highest functional level possible, quickly and safely. They noted a focus on workers' *capabilities*, rather than on their work restrictions. Again, they emphasized the importance of case managers communicating with the worker, provider, and employer.

5. Partnerships and Teamwork

Informants raised the notion of partnership in terms of:

- getting buy-in from all stakeholders
- enhancing communication among all players, and
- creating a non-adversarial system.

They noted the importance of understanding the perspectives and needs of providers, employers, insurers, and injured workers. The specific partnerships varied from program to program, depending on the players involved. One informant pointed to the close linkage of his health care delivery program to a union-based health and safety department.

6. Other Quality Enhancers

In addition to the program components discussed above, informants noted the following other components that enhance the quality of their programs' medical care and services:

- medical records review process
- use of research-based treatment guidelines
- credentialing of facilities, not just of providers
- a respectful, caring service philosophy
- a value on patient education
- multi-lingual assistance with claims filing
- physician-driven, patient-centered care.

N. Least Successful Aspects of the Programs

In general, informants had less to say about ineffective program components than about effective ones. Several informants said their programs were too new for them to comment on which components were least successful. Those who did comment mentioned the following factors.

1. information systems
2. access to providers and services
3. injury prevention
4. return to work
5. balancing costs and quality
6. state regulations and administrative complexities.

Informants' observations in each of these areas are summarized below.

1. Information Systems

In discussing least successful program features, a number of informants pointed to inadequacies in information systems. Specifically, they cited their lack of ability to analyze data and measure outcomes. One informant also noted problems in moving from paper claims and billing systems to electronic systems requiring precision in data entry.

2. Access to Providers and Services

In terms of access, informants noted the following deficiencies:

- difficulty finding the best physicians in every location (to be addressed by expanding the definition of gatekeeper)
- desired medical specialties not represented at each clinic
- Less than ideal ability to channel injured workers to correct providers and decrease out-of-network care
- facility open only three days a week
- staff not large enough to fully handle the need for worker advocacy services.

3. Prevention

Several respondents noted deficiencies in the area of primary prevention. One referred specifically to the need for renovation of facilities and work areas.

4. Return to Work

Two informants pointed to the lack of vocational rehabilitation to assist in returning injured workers to work. One informant noted that employers may not create necessary light duty options if case management programs lack vocational management components.

5. Balancing Costs and Quality

Comments from three informants suggested difficulties in achieving a balance between quality and cost control.

- Quality may decrease in response to fees being discounted too low, as providers start to over-utilize.
- Utilization review is very costly due to its labor intensiveness. (One program will try to address this by requiring a select group of providers to use treatment protocols while not requiring them to seek authorization for every procedure. These providers' compliance with the treatment protocols will be monitored using practice management software.)
- Large health care companies, which achieve some cost efficiencies, have more difficulty being as client-focused as smaller companies.

6. State Regulations and Administrative Complexities

A number of informants pointed to administrative constraints and complexities, sometimes created by their state regulatory environments.

- Employee direction, or limited employer direction, limits program success.
- Requiring state authorization of physicians for workers' compensation interferes with health plans bringing providers in who have not treated workers' compensation cases previously. Some of the problems of the system continue because doctors who have developed "bad habits" continue to treat injured workers.
- For integrated (24 hour) programs, having different lines of coverage for regular group health and workers' compensation coverage causes problems, due to different state rules governing the different benefits.
- Not paying or administering lost time benefits means the program must have multiple relationships for coordination of functions.
- Requiring employee access to two workers' compensation MCOs decreases ability to improve communication and coordination.
- Varying the number of days of employer ability to direct care (as in California) is a hindrance.
- There is a potential for state legislation that would prohibit performance-based differential pay for physicians.

O. Recommendations for the Development of Successful Programs

When asked how they would advise administrators interested in developing successful workers' compensation medical benefits programs, informants offered recommendations related to:

1. program planning
2. program structure/components
3. provider network
4. partnerships and division of responsibilities among involved parties.

Informants' recommendations under each of these topics are summarized below.

1. Program Planning

In terms of program planning, informants offered four recommendations.

- Get input and buy-in from all customer groups (employers, WC carriers, and labor representatives).
- Know your customers' needs and design the program to meet them.
- Think through the details and have all the pieces in place prior to implementation.
- Think "outside the box," creatively, rather than doing what has always been done.

2. Program Structure/Components

With the exception of three informants who recommended the 24-hour approach, recommendations about program structure varied from informant to informant, as listed below.

- Keep administrative structure relatively simple.
- Structure in risk sharing.
- Have the provider network, case management, and bill paying services together, instead of pulling together three different companies to provide these services.
- Do not allow "opt out" until 90 days post injury.
- Keep second opinions within the network.
- Have a gatekeeper system wherein primary care physicians oversee medical management.

In terms of program components, a number of informants emphasized the importance of:

- a focus on prevention Ä of both injuries and disability
- early intervention
- provider and employer demonstration of sincere interest in the worker's well-being
- employer involvement
- wage replacement.

Other program components seen as important were:

- high quality occupational medicine
- capacity to identify and manage early indicators of potential problems with recovery and/or return to work
- patient advocacy and support
- integration of: prevention, case management, and quality measurement
- well-designed return-to-work guidelines
- employer incentives for implementing return-to-work programs
- electronic data management systems to allow: ease of communication with MCOs, use of electronic clinical protocols, and evaluation of program effectiveness.

3. Provider Network

Informants offered a number of recommendations concerning the organization, size, and composition of provider networks, and the compensation of providers. In terms of organization, they recommended the following.

- Organize providers as a PPO.
- Credential providers.*
- Have contractual expectations related to communication, interaction with nursing staff, and use of treatment protocols.

With regard to the size and composition of the network, informants had the following advice.

- Use a very selective, small network to ensure quality of care and effective communication.
- Use providers focused on workers' compensation – and who have an understanding of the workplace – and create the network based on types of providers, rather than on the number of providers.
- Employ providers dedicated to evaluating injured workers quickly and getting them through the system.
- Select providers who care about injured workers, and are willing to work within a structured health care delivery system and with case managers.
- Involve workers in decisions regarding provider panels.
- Select provider groups on the basis of specialist availability and quality.
- Have occupational medicine physicians *responsible* for diagnosis, treatment, case management, and return to work, even if they do not personally provide all the treatment.
- Include those specialists who are important in the treatment of workplace injuries.
- Contract with specialists to consult with nurse case managers.

In addition, several informants had suggestions about provider pay and incentives.

- Put providers at risk for indemnity losses, with incentives for indemnity cost declines.
- Pay full cost, not discounted fees, which attracts higher quality providers and results in lower indemnity costs.
- Pay providers fairly, based on achievement of outcomes.
- Align incentives to encourage timely return to work.

4. Partnerships and Division of Responsibilities among Involved Parties

A number of informants focused on the importance of fostering communication, collaboration, and coordination among all involved parties (providers, employers, injured workers, payors and claims personnel) in order to achieve quality care and cost control. One informant suggested that an integrated information system could facilitate communication among parties and prevent service duplication. A second advised setting expectations that all parties could work together to meet. A third argued for not only communicating with, but also training, everyone affected by the program.

* With regard to this recommendation, it should be noted that one informant stated that programs that credential providers have not worked well in general.